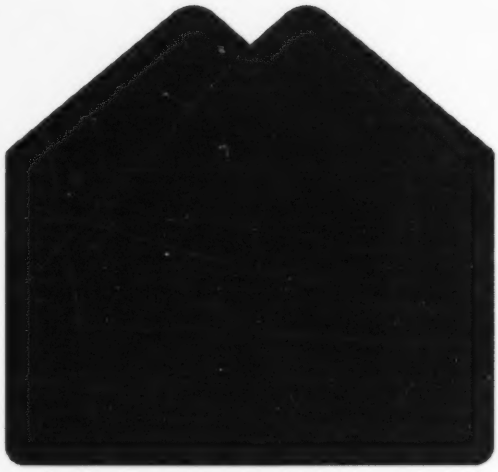
The New Brunswick Extra-Mural Program



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New Nouveau
Brunswick
CANADA

Health and Wellness

THE EVOLUTION OF HOME HEALTH CARE IN NEW BRUNSWICK

In 1979, an interdepartmental committee recommended to the New Brunswick Department of Health that a new health system component was required to manage the foreseeable changes in the population and address heavy utilization of hospital beds. As a result, a new entity, the Extra-Mural Hospital (now referred to as the Extra-Mural Program) was formed with a broad mandate to;

- Provide an alternative to hospital admissions,
- Facilitate early discharge from hospitals,
- Provide an alternative to, or postponement of, admission to nursing homes,
- Provide long term care,
- Provide rehabilitation services,
- Provide palliative care, and
- Facilitate the coordination and provision of support services.

The New Brunswick Extra-Mural Program (EMP) accepted its first clients in 1981. The program was implemented on a gradual basis over the following 12 years and since 1993 covers every region and area in the province.

EMP was not seen as an immediate means of reducing health care costs. The economic benefits of the EMP were recognized to be long term and would result partly from the economies of not building beds.

EMP's ongoing growth and development:

- In 1989, the responsibility for long term nursing care was transferred from Public Health to Extra-Mural.
- In 1991, Extra-Mural partnered with Family and Community Services in a single entry point project to provide health and social services to individuals over 65. This program was later expanded in 1997 to include adults with disabilities.
- In 1996, responsibility for Extra-Mural was transferred to the Regional Hospital Corporations and it became the Extra-Mural Program.
- In 1997, all community rehabilitation services, including those provided to the schools and nursing homes, were consolidated under the auspices of the EMP.

The Department of Health and Wellness (DHW) is responsible for the overall, provincial direction of the EMP. The department, in collaboration with the Regional Health Authorities (RHA's):

- Directs the development of the program,
- Fosters the maintenance of provincial forums to direct and advise on issues relating to the program,
- Assures the availability of consistent home health care services throughout the province,
- Establishes provincial policy and standards, and
- Funds and monitors the program.

Each RHA is responsible for the delivery of EMP services within its region.

PROGRAM DESCRIPTION

The mission of the EMP is

> *"to provide a comprehensive range of coordinated health care services for individuals of all ages for the purpose of promoting, maintaining or restoring health within the context of their daily lives, and to provide palliative services to support quality end of life care for individuals with progressive life threatening illnesses."*

This mission is accomplished through the provision of a Basket of Services, including acute care, palliative care, long term care, rehabilitation, and oxygen therapy. Professional services include physicians, nursing, occupational therapy, physiotherapy, speech language pathology, respiratory therapy, social work and clinical nutrition. Diagram A below presents a graphic summary description of the EMP.

Thirty service delivery sites in New Brunswick provide EMP nursing services on a 24 hours-a-day, 365 days-a-year basis. This is accomplished through nursing shifts or, at a minimum, the on-call services of a nurse. EMP arranges for limited short term home support services like personal care. This service is used primarily with palliative care patients to enhance and support the informal support network in the last weeks of the patient's life.

Home support services required on a long term basis are accessed through the single entry point assessment program and are funded through the Department of Family and Community Services.

All residents of New Brunswick who meet program eligibility criteria have access to EMP services. A physician referral is required for admission to the program, with the exception of rehabilitation services, in which direct referrals from self/family/others are accepted.

EMP services are delivered according to provincial clinical policy and procedures to ensure the provision of consistent quality home health care services throughout the province. Core EMP functions include assessment, intervention, consultation and collaboration, education and training, and service planning and coordination. Clients who are accepted for home health care services receive the necessary drugs and supplies to support the intervention required, based on need and reason of referral to the program. The EMP is the payer of last resort for all drugs, with the majority of clients receiving support from other payers.

The program operates based on the client-centered model of service delivery in which services are delivered according to the assessed needs of the client and family, and a mutually agreed-upon care and discharge plan. EMP providers are specialists in the delivery of home health care services, rather than specialists in specific disease or program areas. This approach ensures the delivery of safe, efficient and effective care, and facilitates continuity of acute care.

All EMP non-physician professional service providers are employees of the program and report to the management team of the service delivery unit. This structure facilitates close interdisciplinary team work and reduces the number of service providers involved with the client and family without diminishing the quality of care. One team member is responsible, as the primary care provider, for the coordination of care and service planning.

The Liaison Nurse is a key position in the organization: the coordination of care among hospital, home and the community has been essential to the success of the program. The Liaison Nurse fulfills this responsibility by:

- Engaging in cooperative discharge planning between the hospital and home,
- Reducing inappropriate admission by arranging for home and community services,
- Informing and educating hospital personnel of both the scope and the limitations of the Program,
- Providing information to the client and families, and
- Arranging for necessary services and equipment prior to discharge from a hospital facility.

Physicians are integral members of the EMP home care team and are remunerated on a fee-for-service basis for services provided to homecare clients (visits, telephone, consultations, admissions). Physician involvement in the provision of home healthcare services has been a critical factor in the overall success of the program.

Diagram A: Summary Description of the EMP

The EMP service delivery model has evolved over the years, and continues to be based on a client-centered approach and the following beliefs;

1. All New Brunswickers have access to home health care services, when required, in the home and community environment, in order to progress towards and maintain an optimal level of health.
2. Home health care is holistic in nature and is delivered through the provision of coordinated services. In order to meet the identified needs of the client, service providers recognize the contribution of other providers, establish effective communication and work together in partnership.
3. Home health care service must be delivered in an environment that is safe for the client and the EMP service provider.
4. The client's culture, experiences, knowledge and rights are central to, and carry authority within, the client/service provider relationship. Services provided are responsive to the needs of the client.
5. Home health care services are best provided through an interdisciplinary team with case coordination for each client and family.
6. A continuous quality improvement approach is essential in the provision of home health care services that are responsive to the changing needs of clients and the community.
7. Home health care services must support and incorporate the appropriate use of client self care and service providers, both formal and informal.
8. Relevant training and education of other health service providers, based on the needs of the client, are essential in the provision of quality home health care services.
9. Development and maintenance of an ongoing learning environment are essential to recruit and maintain competent, innovative, effective and efficient service providers.

EXTRA-MURAL PROGRAM FUNDING AND STATISTICS

The DHW funds the EMP through a protected budget within the global funding envelope of each RHA. Fiscal 2002-03 actual EMP total expenditures are estimated at $42.3 million; the budget for 2003/2004 is $43.8 million, representing approximately 3% of the total Department of Health and Wellness budget. Total expenses include the following: salaries and benefits, drugs, oxygen, medical and other supplies, referred-out services, equipment, fleet, sundry, buildings, and leases.

In 2001/2002 salaries and benefit expenses comprised 78% of total expenses whereas drug and oxygen and supplies expenses reflected 12% of total expenses.

The EMP has over 640 funded full time equivalent positions in the province. In 2001/2002, 18,359 clients were discharged from the program. 453,813 visits (321,905 nursing visits and 131,911 other professionals' visits) were carried out along with 119,575 telephone contacts (provision of service to client and family over the telephone).

Approximately 62% of the clients served are over the age of 65 (65-74 years: 16%; 75-84 years: 26%; and over 85 years: 20%). Children and adolescents (0-18 years) make up 11% of clients served and adults (19-64 years) 27% of clients served.

Nursing is involved with approximately 70% of the clients admitted to EMP. 70% of these nursing clients require acute care services and 30% require long term care services.

Children and adolescents service needs are primarily for rehabilitation services in the home and school environments. Rehabilitation services are also provided to clients in nursing homes.

STATISTICS - 2001 / 02

	Visits	Telephone Contacts
Nursing	321,905	83,677
Occupational Therapy	25,207	10,968
Physiotherapy	29,591	7,550
Respiratory Therapy	24,407	4,388
Registered Dietitian	13,206	4,498
Social Worker	5,239	2,260
Speech Language Pathology	34,258	5,814
Admissions		17,964
Discharges		18,359
Average Cost per visit		$89.0
Cost per nursing workload unit (minute)		$1.15
Cost per rehab workload unit (minute)		$1.14
Admissions per 1000 population		26.19

Approximately 4-5% of the EMP caseload receives palliative care and 5% is receiving home oxygen therapy on a long term basis.

LESSONS LEARNED FROM THE NB EXPERIENCE IN HOME CARE

1. The acute care substitute function of home care requires a comprehensive team, working collaboratively to meet the needs of the client and family. An essential component of acute care services is the provision of appropriate short term home support services, e.g., personal care. The requirement for short term support services as a component of acute care services is often overlooked, as it is assumed that the informal support system will address these specific needs. The provision of adequate short term support needs to be addressed for the replacement/substitution function of home care to occur in a fashion that ensures quality service for the client and family.

2. Increased utilization of acute home care services in NB has been the result of several factors including;
   - Planned design of a comprehensive home health care system;
   - Awareness of the gaps in health care services, recognizing the potential for care in the community and development of solutions to address the gaps;
   - Commitment by all stakeholders to the importance of the role of home and community care and the advantages of caring for individuals at home;
   - An increase in ambulatory/day surgery procedures that require home health care as a follow up;
   - Responding to technological advances in health care, i.e., equipment;
   - Consumer demand for services in the home, i.e., palliative care;
   - Physicians' support of the program.

3. Home health care needs to communicate what it can deliver but also more importantly what it cannot deliver. One must guard against the assumption that because something can be done at home, it **should** be done at home, it **must** be done at home. This is not sufficient justification; it ignores many of the complex factors found in the home environment including the suitability of the home for the service, i.e., safety for the client and service providers; the presence or the lack of a support network; and the capacity of the support network and service providers to provide the required care.

4. Home health care is not "cheap" care, it is not second class care, it is first class care appropriate for the needs of the client and family. Unfortunately, many promote home health care as the panacea to health care problems, exaggerating the bottom line benefits rather than focusing on home care as one of many appropriate options for service delivery.

5. It is challenging to fund the growth of home health care within an environment of growing pressures on the entire health care system. The same pressures affecting institutional care are also impacting home health care services, e.g., rising costs of drugs, health human resource shortages, technological advances in equipment and interventions, etc.

SUMMARY

Home health care is a legitimate, identifiable component of the New Brunswick health care system with its own role to play in the continuum of care, a role on par with ambulatory and institutional care. The Extra-Mural Program is an acceptable option for the delivery of health care in our province, and for many acute care, long term care and palliative care clients, it is the first and optimal choice for care. The quality of the current program is a testament to the strength of the foundation that was laid in the early 1980s.

The Extra-Mural Program has reached maturity but not finality. It remains adaptable and embraces ongoing change and challenges in an effort to contribute to sustainable quality health care services in the province.